STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. BUILDING 00 B. WING	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00103299. Complaint IN00103299-Substantiated. Federal/State deficiencies related to the allegations are cited at F309, F425 and F514. Survey dates: February 29 and March 1, 2012 Facility number: 000272 Provider number: 155377 AIM number: 100274710 Survey team: Cheryl Fielden, RN-TC Janie Faulkner, RN Census bed type: SNF/NF: 76 Total: 76 Census payor type: Medicare: 9 Medicaid: 61 Other: 6 Total: 76 Sample: 4	F0000	**PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION IN GENERAL, OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES.** **The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility is requesting a DESK REVIEW of compliance for this plan of correction.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on March 6, 2012 by Bev Faulkner, RN			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure a resident received an ordered wound care treatment to promote healing. This affected 1 of 3 residents reviewed for wound care treatments in a sample of 4. (Resident # D) Findings included: The record of Resident # D was reviewed on 2/29/12 at 3:45 P.M. The resident had an order with an origination date of 11/26/11 to apply Santyl/Polysporin 1:3 ointment after cleansing right buttock wound with normal saline, then to cover with calcium alginate, and secure with a clear dressing. The order was to change daily and as needed. On 2/29/2012 at 1:28 P.M., the ADON was observed preparing for the wound treatment for Resident # D. The ADON was observed to unlock the treatment cart and opened two drawers and stated, "no	F0309	**F-309 Provide care/services for** **Highest well being.** **What corrective action(s) will be** **Accomplished for those residents Found to have been affected by the Deficient practice:** · Resident D is receiving wound care treatment per Physician order **How will you identify other residents** **Having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents receiving wound care treatments have the potential to	03/31/2012

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	Santyl and Polysporin for wound treatment" "It should have been reordered from the pharmacy by whoever used it last." The ADON was then observed to remove sterile gauze pads, small bottle of normal saline, and alginate from the treatment cart. During observation of the treatment, the ADON cleansed the wound on right buttock with gauze dressing and sterile water, dried with sterile gauze, and placed alginate on wound bed and covered the wound with coverall dressing. The ADON stated, "I do (resident's name) treatments to his wound, it has really improved. I will call the doctor and let him know I didn't have the Santyl and Polysporin for treatment and I'll call the pharmacy and ask them to send it so I'll have it for the treatment tomorrow. This was not caused by pressure, it was caused when the resident bumped his right hip on his wheelchair causing tissue death." Review of the January 2012 Medication Administration Record (MAR) , lacked documentation of the wound treatment being completed on January 5 and the 27th. The February 2012 Medication Administration Record lacked documentation the wound treatment was completed on February, 7, 17, and 21.		be affected by the alleged deficient practice. · The licensed nurses will be in serviced by the DNS/designee 3/20/12 on administering treatments per order, and re-ordering medications/treatments. Post test included. · All residents receiving wound treatments have been reviewed to ensure that the ordered treatment is available and that treatments have been completed per order evidenced by initialed box. · The director of nursing services/designee is responsible to ensure compliance **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** · The licensed nurses will be in serviced by the DNS/designee 3/20/12 on administering treatments per order, and re-ordering treatments. Post test included. · All residents receiving wound treatments have been reviewed to ensure that wound treatments have been documented as complete per order evidenced by initialed box. · Unit manager/designee will review all meds/treatments ordered from pharmacy daily to ensure delivered timely. Meds/treatments found not to be delivered- a call to the pharmacy will be made to stat the order or call into the back-up pharmacy. · The director of nursing services/designee is responsible	

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	During an interview with the ADON on 2/29/2012 at 1:45 P.M., she indicated that if the treatment is done, it should have the nurse's initials or signature. If not done the nurse is supposed to circle the date and note on the back the of medication administration record and in nurse's note the resident refused treatment or the medication for treatment was not available. The only documentation on the treatment record and nurse's note was from the ADON on 2/29/12 that indicated there was no Santyl and Polysporin for Resident # D's ordered wound treatment. This federal tag relates to Complaint IN00103299. 3.1-37(a)		to ensure compliance · Non-compliance will result in further education including disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** · Unit manager/designee will review all meds treatments ordered from pharmacy daily to ensure delivered timely. Meds/treatments found not to be delivered- a call to the Pharmacy will be made to stat the order or call into the back-up pharmacy. · All residents receiving wound treatments will be reviewed daily using the CQI audit tool- Medication / Treatment / Pharmacy Audit x 4 weeks, bi-weekly x 2 months, monthly x 3 months and for 2 quarters thereafter. · Findings from the CQI process and trends will be reviewed monthly and an action plan will be implemented for threshold below 95%. **Date of Compliance: 3/31/12**	

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F0425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview, and record review, the facility failed to ensure a resident's ordered medicated ointment was available for use to promote wound healing. This affected 1 of 3 residents reviewed for wound care treatment in a sample of 4. (Resident # D) Findings included: The record of Resident # D was reviewed on 2/29/12 at 3:45 P.M. The resident had an order with an origination date of 11/26/11 to apply Santyl/Polysporin 1:3	F0425	**F-425 Pharmaceutical SVC – accurate procedures, RPH** **What corrective action(s) will be** **Accomplished for those residents Found to have been affected by the Deficient practice:** · Resident D is receiving wound care treatment per Physician order	03/31/2012

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	ointment after cleansing right buttock wound with normal saline, then to cover with calcium alginate, secure with a clear dressing. The order was to change daily and as needed. On 2/29/2012 at 1:28 P.M., the ADON was observed preparing for the wound treatment for Resident # D. The ADON was observed to unlock the treatment cart and opened two drawers and stated, "no Santyl and Polysporin for wound treatment" "It should have been reordered from the pharmacy by whoever used it last." The ADON was then observed to remove sterile gauze pads, small bottle of normal saline, and alginate from the treatment cart. During observation of the treatment, the ADON cleansed the wound on right buttock with gauze dressing and sterile water, dried with sterile gauze, and placed alginate on wound bed and covered the wound with coverall dressing. The ADON stated, "I do (resident's name) treatments to his wound, it has really improved. I will call the doctor and let him know I didn't have the Santyl and Polysporin for treatment and I'll call the pharmacy and ask them to send it so I'll have it for the treatment tomorrow." The review of the Medication		**How will you identify other residents** **Having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents receiving wound care treatments have the potential to be affected by the alleged deficient practice. · The licensed nurses will be in serviced by the DNS/designee 3/20/12 on administering treatments per order, and re-ordering treatments. Post test included. · All residents receiving wound treatments have been reviewed to ensure that the ordered treatment is available and that treatments have been completed per order evidenced by initialed box. · The director of nursing services/designee is responsible to ensure compliance **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** · The licensed nurses will be in serviced by the DNS/designee 3/20/12 on administering treatments per order, and re-ordering treatments. Post test included. · All residents receiving wound treatments have been reviewed to ensure that wound treatments have been documented as complete per order evidenced by initialed box. · Unit manager/designee will review all meds/treatments ordered from	

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	Administration Records for January and February of 2012, lacked documentation for wound care treatments to right buttock on January 5th and 27th and on February 7th, 17th, and 21st, 2012. This federal tag relates to Complaint IN00103299. 3.1-25(a)		pharmacy daily to ensure delivered timely. Meds/treatments found not to be delivered- a call to the pharmacy will be made to stat the order or call into the back-up pharmacy. · The director of nursing services/designee is responsible to ensure compliance · Non-compliance will result in further education including disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** · Unit manager/designee will review all meds treatments ordered from pharmacy daily to ensure delivered timely. Meds/treatments found not to be delivered- a call to the Pharmacy will be made to stat the order or call into the back-up pharmacy.. · All residents receiving wound treatments will be reviewed daily using the CQI audit tool- Medication / Treatment / Pharmacy Audit x 4 weeks, bi-weekly x 2 months, monthly x 3 months and for 2 quarters thereafter. · Findings from the CQI process and trends will be reviewed monthly and an action plan will be implemented for threshold below 95%. **Date of Compliance: 3/31/12**	

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F0514	**-514 Records-complete/accurate/accessible** **What corrective action(s) will be** **Accomplished for those residents Found to have been affected by the Deficient practice:** · Resident D is receiving wound care treatment per Physician order **How will you identify**	03/31/2012

Based on record review and interview, the facility failed to ensure complete and accurate documentation in the clinical record of one of one resident reviewed for complete and accurate records in a sample of 4. (Resident # D)

Findings included:

During the record review for Resident # D on 2/29/2012 at 3:45 P.M., the review of the Medication Administration Records for January and February of 2012 lacked documentation for wound care treatments to right buttock on January 5th and 27th and on February 7th, 17th, and 21st, 2012.

The January 2012 recapitulation orders included an order, dated 11/26/11, for Santyl/Polysporin ointment: "cleanse area on right buttock with normal saline, apply

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	ointment cover with calcium alginate secure with clear adherent dressing change daily and as needed." During an interview with the ADON on 2/29/2012 at 1:45 P.M., she indicated that if the treatment is done, it should have the nurse's initials or signature. If not done the nurse is supposed to circle the date and note on the back the of medication administration record and in nurse's note the resident refused treatment or the medication for treatment was not available. 3.1-50(a)(1) 3.1-50(a)(2)		**other residents** **Having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents receiving wound care treatments have the potential to be affected by the alleged deficient practice. · The licensed nurses will be in serviced by the DNS/designee 3/20/12 on administering treatments per order, and re-ordering medications/treatments. Post test included. · All residents receiving wound treatments have been reviewed to ensure that the ordered treatment is available and that treatments have been completed per order evidenced by initialed box. · The director of nursing services/designee is responsible to ensure compliance **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** · The licensed nurses will be in serviced by the DNS/designee 3/20/12 on administering treatments per order, and re-ordering treatments. Post test included. · All residents receiving wound treatments have been reviewed to ensure that wound treatments have been documented as complete per order evidenced by initialed box. · Unit manager/designee will review all meds/treatments ordered from	

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			pharmacy daily to ensure delivered timely. Meds/treatments found not to be delivered- a call to the pharmacy will be made to stat the order or call into the back-up pharmacy. · The director of nursing services/designee is responsible to ensure compliance · Non-compliance will result in further education including disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** · Unit manager/designee will review all meds treatments ordered from pharmacy daily to ensure delivered timely. Meds/treatments found not to be delivered- a call to the Pharmacy will be made to stat the order or call into the back-up pharmacy. · All residents receiving wound treatments will be reviewed daily using the CQI audit tool- Medication / Treatment / Pharmacy Audit x 4 weeks, bi-weekly x 2 months, monthly x 3 months and for 2 quarters thereafter · Findings from the CQI process and trends will be reviewed monthly and an action plan will be implemented for threshold below 95%. **Date of Compliance: 3/31/12**	